

# Mentally Disordered Offenders in Sweden

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**This article reviews the laws in Sweden concerning mentally disordered offenders. It also contains some figures on the relationship between mentally disordered offenders and other offenders sentenced to prison. The rules in Sweden are very different from other countries in that the responsibility concept has been abolished and thus there is no acquittal on a psychiatric basis.**

Before 1965, when the new Swedish Criminal Code (Brottsbalken) came into force, the principle aim of a Swedish forensic psychiatric examination was to establish whether the offender was fully responsible and therefore culpable when the crime was committed. If the offender was found to be "in his right mind," he was held to be accountable for his actions and was punished in accordance with the law. But if, for instance, a person was found to be suffering from insanity at the time of the crime, the provisions of the Penal Code allowed that he could not be held responsible for his criminal acts and must be acquitted. The mentally ill offender was not to be punished but committed to a mental hospital for treatment.

Psychosis and severe mental deficiency were considered sufficient reason for acquittal, along with four other disordered mental states included in *Memo*

*No. 1*, issued by the Ministry of Justice in 1946. In terms of contemporary psychiatry, these were: (1) severe cases of constitutional psychopathy; (2) serious mental deficiencies caused by brain damage or brain disease; (3) severe neuroses and personality disturbances, including compulsions, i.e., kleptomania, pyromania, paraphilia; and (4) psychiatric states bordering on senile dementia. When a crime was committed under the influence of any of the conditions listed above, the offender was likely to be found not culpable and acquitted.

With the enactment of the new Criminal Code in 1965, the Swedish system of criminal sanctions was modified to reflect a fundamental change of attitudes that included some new basic legal principles, Section 1 (BrB 1:7), of the 1965 Code states:

In choosing applicable sanction, the court shall take into consideration the requirement of upholding general adherence to the law, while paying special heed that the sanction imposed be designed to promote the offender's adjustment to society.

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One of the underlying principles here is that society must always react against crimes and impose suitable sanctions upon those who commit them. Lack of culpability on the basis of mental disorders at the time of the crime was no longer given the same relevance. Thus, everyone who committed a crime was now culpable under the law, since the 1965 Code clearly states that every crime must be followed by imposition of a legal sanction upon the perpetrator. Because mentally ill offenders were no longer to be acquitted, the criminal justice system turned to the question "which sanction is most appropriate in helping the mentally disordered offender readjust to society?"

Under the new Criminal Code of 1965, the mental status of the offender at *the time of trial* now became the deciding factor, not of guilt or innocence, but in determining the appropriate sentence (i.e., whether the offender should be sent to prison or committed to a hospital for psychiatric treatment). The legal principle here was that due consideration be taken of the offender's social readjustment potential. Under this type of rehabilitative model, the role of the forensic psychiatrist also changed. The old Penal Statutes stated that the psychiatrist was to establish whether an offender suffered from a mental disorder at the time of the crime that warranted acquittal. With the enactment of the new Criminal Code, the forensic psychiatrist took on a more dynamic and therapeutic role.

Advocates of the new Criminal Code wished to exclude from sentencing pro-

cedures such metaphysical concepts as "established morals," "duty," "culpability," "guilt," "punishment," and "expiation." This resulted in a criminal code based on two main principles, of which one was more or less self-evident, while the other was highly controversial. The first was that society must protect itself against acts of crime by the imposition of fixed or legally stipulated sanctions upon criminals. The second was the so-called "individual or special prevention principle" underlying Section 1:7 of the Criminal Code (BrB 1:7), which is the basis of the "Swedish model." This has led to frequent and emotionally charged debate pertaining to whether mentally disordered offenders who are not clearly psychotic should be committed to hospital for psychiatric treatment rather than sent to prison. Under this system the question of whether psychiatric treatment has a crime preventive effect on mentally disordered offenders has taken on fundamental importance.

### **Forensic Psychiatric Examinations in Sweden**

Forensic psychiatric examinations are decided upon by the court and must be carried out before a decree of commitment to psychiatric care can be imposed. However, if a suspect is in a mental hospital already (having committed a crime while on leave), forensic psychiatric examinations are not required, provided that assurances of continued treatment are substantiated by the chief physician and confirmed by the National Board of Health and Welfare.

The ordering of a forensic psychiatric

examination by the court is conditioned upon the suspect confessing to the crime or there being highly probable grounds for supposing his guilt. These examinations must be completed within a period of six weeks.

The report based on the forensic psychiatric examination concerns the offender's mental state and contains a statement relating to the possibility of providing the offender with treatment under the National Mental Health Act. Admission to a hospital takes place as quickly as possible following a court decision recommending commitment to institutional psychiatric care. Offender patients are sent to their local psychiatric hospitals if they are not considered dangerous. Those who are considered dangerous (approximately half) are sent to security units.

The rules for the discharge of individuals committed for psychiatric care by a court of law are the same as for other patients, i.e., the conditions for the provision of treatment stipulated in the Mental Health Act no longer exist. The right of decision lies with an independent discharge board consisting of a judge and a psychiatrist—neither of whom are associated with the case in the court or the hospital in question—and three politically appointed laymen.

### **Treatment of Mentally Disordered Offenders**

Very few offenders are committed to psychiatric care in Sweden. In 1987, only 350 individuals were committed to closed psychiatric care, of one percent of the population of convicted offenders.

Since statistics show that no less than eight percent of the Swedish population in the same age range are admitted to psychiatric hospitals for care,<sup>1</sup> it might appear that those who commit crimes enjoy better mental health than the Swedish population as a whole. Of course, this is simply not true. In fact, a very high proportion of those convicted of *serious* crimes of violence are committed for psychiatric care. In murder or manslaughter cases this figure is approximately 70 percent. Furthermore, a substantial proportion (1/5) of those convicted of sexual crimes and arson are also committed for psychiatric care.<sup>2</sup> Most of those committed for care are not psychotic but suffer from severe personality disorders, brain damage, or compulsions. Sweden differs from all the other Scandinavian countries, where the practice is to commit only psychotic individuals to psychiatric care.

It should be pointed out that there are no psychiatric hospitals within the prison system in Sweden, as, for instance, there are in Britain. In Sweden there are only two small psychiatric wards comprising 30 beds and used mainly for emergency cases. For comparison purposes, the number of persons in Swedish prisons on December 31, 1987, was 4,406.

Incarcerations in prison and commitment to special units are very similar in length of time served, with the exception of those who are sentenced to prison for murder or manslaughter. Those sent to prison for these crimes remain there approximately twice as long as similar offenders committed for psychiatric care.<sup>3</sup>

This differs from recently reported detention times in Ontario, Canada,<sup>4</sup> where insanity acquittees (for homicide) spent the same length of time in custody as their convicted counterparts in prison. On the other hand, those in Sweden committed to psychiatric care for less serious crimes spent a longer time in custody than their counterparts in prison, as is also the case in Ontario, Canada.<sup>4</sup>

### The Crime Preventive Effect of Psychiatric Treatment

In a recent study, Belfrage<sup>3</sup> found that all offenders who were committed to psychiatric care in security units received some kind of psychiatric treatment, whereas nearly half of those who were committed to psychiatric care in county hospitals were given virtually no treatment at all. This suggests that those with personality disturbances committed to psychiatric care might do better if they were placed in security units.

To what extent can we expect that the treatment given to mentally disordered offenders will enable them to adapt to normal life in the society? Before 1989, varying and even conflicting results had been shown. There were only three studies in Sweden that dealt with recidivism in this particular group. Two of these studies appeared to show that psychiatric treatment has a positive crime preventive effect.<sup>5,6</sup> According to the third, psychiatric treatment "is no more effective than correctional prison care."<sup>7</sup>

Belfrage<sup>8</sup> identified an important source of error that probably led to these conflicting results. He found that psychiatric treatment had a crime preven-

tive effect on violent offenders. Thus, the general question, "Does psychiatric treatment have a greater crime preventive effect than a prison sentence?" will engender contradictory replies of "yes" and "no," depending on the category of offenders studied: "yes" for violent offenders, "no" for property offenders. Boerman,<sup>9</sup> too, noted that a large number of mentally disordered offenders showed a decreasing tendency to violence during and after imposed psychiatric care.

However, there is still a serious lack of research in this field. After 25 years' experience of providing psychiatric treatment, as prescribed in the Criminal Code of 1965, we cannot identify the impact of psychiatric care on mentally disordered offenders. It is therefore crucial that further research be aimed at delineating any crime preventive factors and health-promoting effects of psychiatric treatment.

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### Erratum

In the September 1991 issue of the *Bulletin* (Vol. 19, pp. 237-248) in the article "Opinions by AAPL Forensic Psychiatrists on Controversial Ethical Guidelines: A Survey," Gregory B. Leong's name inadvertently appeared as Gregory G. Leong and was also incorrectly listed in the contents pages. The printer regrets the error.